a rural health clinic (RHC), that is so led by a physician assistant.

(c) *Additional requirements for the Medicaid EP.* To qualify for an EHR incentive payment, a Medicaid EP must, for each year for which the EP seeks an EHR incentive payment, not be hospital-based as defined at §495.4 of this subpart, and meet one of the following criteria:

(1) Have a minimum 30 percent patient volume attributable to individuals enrolled in a Medicaid program.

(2) Have a minimum 20 percent patient volume attributable to individuals enrolled in a Medicaid program, and be a pediatrician.

(3) Practice predominantly in a FQHC or RHC and have a minimum 30 percent patient volume attributable to needy individuals, as defined at §495.302.

(d) *Exception.* The hospital-based exclusion in paragraph (c) of this section does not apply to the Medicaid-EP qualifying based on practicing predominantly at a FQHC or RHC.

(e) *Additional requirement for the eligible hospital.* To be eligible for an EHR incentive payment for each year for which the eligible hospital seeks an EHR incentive payment, the eligible hospital must meet the following criteria:

(1) An acute care hospital must have at least a 10 percent Medicaid patient volume for each year for which the hospital seeks an EHR incentive payment.

(2) A children's hospital is exempt from meeting a patient volume threshold.

(f) *Further patient volume requirements for the Medicaid EP.* For payment year 2013 and all subsequent payment years, at least one clinical location used in the calculation of patient volume must have Certified EHR Technology—

(1) During the payment year for which the EP attests to having adopted, implemented or upgraded Certified EHR Technology (for the first payment year); or

(2) During the payment year for which the EP attests it is a meaningful EHR user.

[75 FR 44565, July 28, 2010, as amended at 77 FR 54160, Sept. 4, 2012]

§495.306 Establishing patient volume.

(a) *General rule.* A Medicaid provider must annually meet patient volume requirements of §495.304, as these requirements are established through the State's SMHP in accordance with the remainder of this section.

(b) *State option(s) through SMHP.* (1) A State must submit through the SMHP the option or options it has selected for measuring patient volume.

(2)(i) A State must select the method described in either paragraph (c) or paragraph (d) of this section (or both methods).

(ii) Under paragraphs (c)(1)(i), (c)(2)(i), (c)(3)(i), (d)(1)(i), and (d)(2)(i) of this section, States may choose whether to allow eligible providers to calculate total Medicaid or total needy individual patient encounters in any representative continuous 90-day period in the 12 months preceding the EP or eligible hospital's attestation or based upon a representative, continuous 90-day period in the calendar year preceding the payment year for which the EP or eligible hospital is attesting.

(3) In addition, or as an alternative to the method selected in paragraph (b)(2) of this section, a State may select the method described in paragraph (g) of this section.

(c) *Methodology, patient encounter*—(1) *EPs.* To calculate Medicaid patient volume, an EP must divide:

(i) The total Medicaid patient encounters in any representative, continuous 90-day period in the calendar year preceding the EP's payment year, or in the 12 months before the EP's attestation; by

(*ii*) The total patient encounters in the same 90-day period.

(2) *Eligible hospitals.* To calculate Medicaid patient volume, an eligible hospital must divide—

(i) The total Medicaid encounters in any representative, continuous 90-day period in the fiscal year preceding the hospitals' payment year or in the 12 months before the hospital's attestation; by

(ii) The total encounters in the same 90-day period.

(3) *Needy individual patient volume.* To calculate needy individual patient volume, an EP must divide—

(i) The total needy individual patient encounters in any representative, continuous 90-day period in the calendar year preceding the EP's payment year, or in the 12 months before the EP's attestation; by

(ii) The total patient encounters in the same 90-day period.

(d) *Methodology, patient panel*—(1) *EPs.* To calculate Medicaid patient volume, an EP must divide:

(i)(A) The total Medicaid patients assigned to the EP's panel in any representative, continuous 90-day period in either the calendar year preceding the EP's payment year, or the 12 months before the EP's attestation when at least one Medicaid encounter took place with the individual in the 24 months before the beginning of the 90-day period; plus

(B) Unduplicated Medicaid encounters in the same 90-day period; by

(ii)(A) The total patients assigned to the provider in that same 90-day period with at least one encounter taking place with the patient during the 24 months before the beginning of the 90-day period; plus

(B) All unduplicated patient encounters in the same 90-day period.

(2) *Needy individual patient volume.* To calculate needy individual patient volume an EP must divide—

(i)(A) The total Needy Individual patients assigned to the EP's panel in any representative, continuous 90-day period in the either the calendar year preceding the EP's payment year, or the 12 months before the EP's attestation when at least one Needy Individual encounter took place with the individual in the 24 months before the beginning of the same 90-day period; plus

(B) Unduplicated Needy Individual encounters in the same 90-day period, by

(ii)(A) The total patients assigned to the provider in that same 90-day period with at least one encounter taking place with the patient during the 24 months before the beginning of the 90-day period, plus

(B) All unduplicated patient encounters in the same 90-day period.

(e) For purposes of this section, the following rules apply:

(1) A Medicaid encounter means services rendered to an individual on any one day where:

(i) Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act) paid for part or all of the service.

(ii) Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act) paid all or part of the individual's premiums, co-payments, and cost-sharing.

(iii) The individual was enrolled in a Medicaid program (or a Medicaid demonstration project approved under section 1115 of the Act) at the time the billable service was provided.

(2) For purposes of calculating hospital patient volume, both of the following definitions in paragraphs (e)(2)(i) and (e)(2)(ii) of this section may apply:

(i) A Medicaid encounter means services rendered to an individual per inpatient discharge when any of the following occur:

(A) Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act) paid for part or all of the service.

(B) Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act) paid all or part of the individual's premiums, co-payments, and/or cost-sharing.

(C) The individual was enrolled in a Medicaid program (or a Medicaid demonstration project approved under section 1115 of the Act) at the time the billable service was provided.

(ii) A Medicaid encounter means services rendered in an emergency department on any 1 day if any of the following occur:

(A) Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act) paid for part or all of the service.

(B) Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act) paid all or part of the individual's premiums, co-payments, and cost-sharing.

(C) The individual was enrolled in a Medicaid program (or a Medicaid demonstration project approved under section 1115 of the Act) at the time the billable service was provided.

(3) For purposes of calculating needy individual patient volume, a needy patient encounter means services rendered to an individual on any 1 day if any of the following occur:

(i) Medicaid or CHIP (or a Medicaid or CHIP demonstration project approved under section 1115 of the Act) paid for part or all of the service.

(ii) Medicaid or CHIP (or a Medicaid or CHIP demonstration project approved under section 1115 of the Act) paid all or part of the individual's premiums, co-payments, or cost-sharing.

(iii) The individual was enrolled in a Medicaid program (or a Medicaid demonstration project approved under section 1115 of the Act) at the time the billable service was provided.

(iv) The services were furnished at no cost; and calculated consistent with § 495.310(h).

(v) The services were paid for at a reduced cost based on a sliding scale determined by the individual's ability to pay.

(f) *Exception.* A children's hospital is not required to meet Medicaid patient volume requirements.

(g) *Establishing an alternative methodology.* A State may submit to CMS for review and approval through the SMHP an alternative from the options included in paragraphs (c) and (d) of this section, so long as it meets the following requirements:

(1) It is submitted consistent with all rules governing the SMHP at § 495.332.

(2) Has an auditable data source.

(3) Has received input from the relevant stakeholder group.

(4) It does not result, in the aggregate, in fewer providers becoming eligible than the methodologies in either paragraphs (c) and (d) of this section.

(h) *Group practices.* Clinics or group practices will be permitted to calculate patient volume at the group practice/clinic level, but only in accordance with all of the following limitations:

(1) The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP.

(2) There is an auditable data source to support the clinic's or group practice's patient volume determination.

(3) All EPs in the group practice or clinic must use the same methodology for the payment year.

(4) The clinic or group practice uses the entire practice or clinic's patient volume and does not limit patient volume in any way.

(5) If an EP works inside and outside of the clinic or practice, then the patient volume calculation includes only those encounters associated with the clinic or group practice, and not the EP's outside encounters.

[75 FR 44565, July 28, 2010, as amended at 77 FR 54160, Sept. 4, 2012]

§ 495.308 Net average allowable costs as the basis for determining the incentive payment.

(a) *The first year of payment.* (1) The incentive is intended to offset the costs associated with the initial adoption, implementation or upgrade of certified electronic health records technology.

(2) The maximum net average allowable costs for the first year are $25,000.

(b) *Subsequent payment years.* (1) The incentive is intended to offset maintenance and operation of certified EHR technology.

(2) The maximum net average allowable costs for each subsequent year are $10,000.

§ 495.310 Medicaid provider incentive payments.

(a) *Rules for Medicaid EPs.* The Medicaid EP's incentive payments are subject to all of the following limitations:

(1) *First payment year.* (i) For the first payment year, payment under this subpart may not exceed 85 percent of the maximum threshold of $25,000, which equals $21,250.

(ii) [Reserved]

(iii) An EP may not begin receiving payments any later than CY 2016.

(2) *Subsequent annual payment years.*

(i) For subsequent payment years, payment may not exceed 85 percent of the maximum threshold of $10,000, which equals $8,500.

(ii) [Reserved]

(iii) Payments after the first payment year may continue for a maximum of 5 years.

(iv) Medicaid EPs may receive payments on a non-consecutive, annual basis.